

09953

CERTIFICATE OF DEATH

09945

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b> c. LENGTH OF STAY IN 1b <b>1 days-19 hrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Orval</b> Middle <b>Carlton</b> Last <b>Bitteringer</b>		4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 15, 1884</b> 9. AGE (In years last birthday) yrs. <b>81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Bitteringer, G. Co. Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Amos Bitteringer</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Brennehan</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>212-24-0912A</b>		17. INFORMANT <b>Mrs. Melvin Sisler, Mt. Lake Park, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary sclerosis</b> DUE TO (c) <b>Arteriosclerosis, generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b> <b>Years</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 26th, 1966</b> to <b>July 4, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 4, 1966</b> , and that death occurred at <b>6:05 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. James H. Feaster, Jr.</b>		22b. DATE SIGNED <b>7-4-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. James H. Feaster, Jr.</b>		22d. ADDRESS <b>Oakland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<b>Burial</b>	<b>7/6/66</b>	<b>Pleasant Valley Cem.</b>	<b>Near Oakland, Md.</b>
24. FUNERAL DIRECTOR <b>John O. Durst, Oakland, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 7 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09954

09946

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Clearfield</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sang Run</b>		c. LENGTH OF STAY IN lb <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>626 Center Street,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SCENECA</b> Middle <b>THOMAS</b> Last <b>CARR</b>		4. DATE OF DEATH Month <b>July</b> Day <b>10th.</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1888</b>
9. AGE (In years birthdate) yrs. <b>78</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hauling</b>	
11. BIRTHPLACE (State or foreign country) <b>Clearfield Co., Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William R. Carr</b>		14. MOTHER'S MAIDEN NAME <b>Carrie Holt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war and dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>706-16-4924</b>	
17. INFORMANT (Widow) <b>Mrs. S.T. Carr,</b>		Address <b>626 Center, Curwensville, Pa.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 4201 DUE TO (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		22. DATE SIGNED <b>7-11-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/11/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Center Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Curwensville, Pa.</b>	
24. FUNERAL DIRECTOR <b>John O. Durst</b> <b>Leighton-Durst Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JUL 13 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FOR STATE HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 12 Film G379 7/26/66 mh									
09955					09947				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Garrett			a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Oakland			b. COUNTY		Allegany		
c. LENGTH OF STAY IN 1b		28 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
Cuppett-Weeks Nursing Home					Rear 319 Offutt Street				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First		Middle		Last		Month		Day Year	
Charles		C.		Cooper		July		14th. 1966	
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	
Male		White		WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 7, 1880		85	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ret.				B&O RR		Unk.		Unknown	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Jacob Cooper					Emma Boltwright				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address				
					B&O RR Records				
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								Hours	
IMMEDIATE CAUSE (a) 4201 Myocardial infarction									
DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								Years	
(b) Arteriosclerotic cardio-vascular disease									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>									
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				7-14-66	
James H. Feaster, Jr., M. D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) Oakland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		July 18, 1966		Oakland Cemetery		Oakland, Maryland			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John O. Durst				Leighton-Durst Funeral Home		JUL 19 1966		Charles Judge	

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FOR STATE  
HEALTH DEPT.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>15 minutes</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MELVIN GORMAN CULLERS</b>		4. DATE OF DEATH Month <b>July</b> Day <b>27th</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1910</b>
9. AGE (In years and birthday) <b>55 yrs.</b>		10. IF UNDER 1 YEAR Months <b>00</b> Days <b>00</b> Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ser. Station Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Service</b>	
11. BIRTHPLACE (State or foreign country) <b>Hardy Co., W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arthur G. Cullers</b>		14. MOTHER'S MAIDEN NAME <b>Sena Mathias</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>232-26-3536</b>	
17. INFORMANT (Daughter) <b>Bonnie Cullers, Rt. 1, Deer Park, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO (b) <b>Coronary arteriosclerosis</b> DUE TO (c) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>Oakland, Md.</b>		22. DATE SIGNED <b>7-27-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/30/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Maysville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Maysville, W. Va.</b>	
24. FUNERAL DIRECTOR <b>John O. Durst</b>		25a. REC'D BY REGISTRAR <b>AUG 1 1966</b>	
Address <b>Leighton-Durst Funeral Home</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>	

MEDICAL CERTIFICATION



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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Mineral</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>14 days-8 hrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>		e. STREET ADDRESS <b>98 W. Hampshire St.</b>	
3. NAME OF DECEASED (Type or print) <b>Lewis</b>		4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 17, 1892</b>
9. AGE (In years lost birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laboratory Technician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paper Mill</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Carmen</b>		14. MOTHER'S MAIDEN NAME <b>Phyllomina Ragne</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>U.S. I</b>		16. SOCIAL SECURITY NO. <b>217-05-6417</b>	
17. INFORMANT <b>Lewis Domenick, Jr.</b>		Address <b>Oakland, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> DUE TO <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>Diabetes Mellitus</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 16, 1966</b> to <b>July 16, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 16, 1966</b> , and that death occurred at <b>11:15 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A.S. Mance</b>		22b. DATE SIGNED <b>17 July 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>A.S. Mance</b>		22d. ADDRESS <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/17, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters</b>	23d. LOCATION (City or Town) (County) (State) <b>Westernport Md.</b>
24. FUNERAL DIRECTOR <b>Ed. Bral</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 20 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>W. J. Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF OHIO

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RECEIVED AT THE OFFICE OF THE COMMISSIONER OF THE LAND OFFICE, COLUMBUS, OHIO, JANUARY 1, 1900.

THE STATE OF OHIO, COUNTY OF [ ]

BEFORE ME, the undersigned authority, on this [ ] day of [ ], 1900,

appeared [ ] personally known to me, and acknowledged to me that he executed the foregoing instrument for the purposes and consideration therein expressed.

Given under my hand and seal of office this [ ] day of [ ], 1900.

Notary Public in and for the State of Ohio.

My commission expires on the [ ] day of [ ], 1900.

Witness my hand and seal of office this [ ] day of [ ], 1900.

Notary Public in and for the State of Ohio.

My commission expires on the [ ] day of [ ], 1900.

Witness my hand and seal of office this [ ] day of [ ], 1900.

Notary Public in and for the State of Ohio.

My commission expires on the [ ] day of [ ], 1900.

Witness my hand and seal of office this [ ] day of [ ], 1900.

Notary Public in and for the State of Ohio.

My commission expires on the [ ] day of [ ], 1900.

Witness my hand and seal of office this [ ] day of [ ], 1900.

Notary Public in and for the State of Ohio.

My commission expires on the [ ] day of [ ], 1900.

Witness my hand and seal of office this [ ] day of [ ], 1900.

Notary Public in and for the State of Ohio.

My commission expires on the [ ] day of [ ], 1900.

Witness my hand and seal of office this [ ] day of [ ], 1900.

Notary Public in and for the State of Ohio.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

09958

09950

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Tucker</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>15 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Albert William Dunithan</b>		4. DATE OF DEATH Month Day Year <b>July 23, 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/28/1882</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maysville, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Geroge Dunithan</b>		14. MOTHER'S MAIDEN NAME <b>Matilda Shirteager</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-09-5404</b>	
17. INFORMANT <b>Mrs. Helen Roy</b>		Address <b>Bayard, W. Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis.</b> DUE TO (b) <b>Thrombocytoma.</b> DUE TO (c) <b>bas</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7-8</b> , 19 <b>66</b> , to <b>7-23</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>7-23</b> , 19 <b>66</b> , and that death occurred <b>06:37A.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. B. L. Grant</b>		22d. ADDRESS <b>Oakland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/25/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bayard Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Bayard W. Va.</b>
24. FUNERAL DIRECTOR <b>Guill N. Minnich</b>		25a. REC'D BY REGISTRAR <b>JUL 27 1966</b>	
ADDRESS <b>Oakland, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
09953		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
09951			
1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville</u> // - 1	
c. LENGTH OF STAY IN 1b <u>25 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett Co. Memorial Hospital</u>		d. STREET ADDRESS <u>Rt. 1, Box 33</u>	
3. NAME OF DECEASED (Type or print) <u>Daisy May Frazee</u>		4. DATE OF DEATH <u>July 31st, 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/29/1890</u> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Friendsville, Md.</u>
13. FATHER'S NAME <u>John Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Ella Meyers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>185-18-0545A</u>	
		17. INFORMANT <u>Mr. Charles Frazee, Friendsville, Md.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary occlusion</u> DUE TO (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fractured left hip.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <u>Fell out of bed 7-18-66 Garr. Co. Mem. Hosp. &amp; fractured hip</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:30 PM 7-18-66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>
		20f. (City or town) <u>Oakland</u> (County) <u>Garr.</u> (State) <u>Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Oakland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/3/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blooming Rose Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Friendsville, Garrett, Md.</u>
24. FUNERAL DIRECTOR <u>Ruth E. Newman</u>		25a. REC'D BY REGISTRAR <u>AUG 3 1966</u>	
ADDRESS <u>Grantsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

09960

09952

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - Oakland</b> c. LENGTH OF STAY IN b. <b>50 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Star Route</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - Oakland Star Route // /</b> d. STREET ADDRESS <b>McHenry</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SIDNEY</b> Middle <b>HARVEY</b> Last <b>HARVEY</b>		4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 26, 1880</b>
9. AGE (In years last birthday) <b>85</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Farming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Deer Park, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Josephus Harvey</b>		14. MOTHER'S MAIDEN NAME <b>Mary Peck</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-38-1304</b>	
17. INFORMANT (Widow) <b>Mrs. Sidney Harvey, Star Rt., Oakland, Md.</b>		Address <b>Star Rt., Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sute Myocardial Infarction</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Vascular Lesion</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19 66</b> Hour a.m. <b>4</b> p.m. <b>28</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>3 yrs</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>June 30, 1966</b> to <b>July 4, 1966</b> , that (I) (we) saw the deceased alive on <b>June 30, 1966</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above.		22. SIGNATURE <b>Ralph Calandrella</b> M.D. 22a. PHYSICIAN'S NAME (Type or print) 22b. DATE SIGNED <b>July 4-66</b>	
22c. ADDRESS <b>Kitzmillers, Md. 21538</b>		22d. ADDRESS <b>Kitzmillers, Md. 21538</b>	
23a. BURIAL, CREMATION, REMAINS <b>Buried</b>		23b. DATE THEREOF <b>July 6, 66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rodeheaver Family Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Near Oakland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Durst</b> ADDRESS <b>Oakland, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 8 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



09952

DEPARTMENT OF STATE

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General - Ireland

Mr. [Name]

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Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

Mr. [Name]

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09961

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09953

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Allegheny</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Oakland</b>		c. LENGTH OF STAY IN lb <b>Minutes</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsburgh</b>		75.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>1229 Washington Road,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Patrick</b> Middle <b>Mark</b> Last <b>Higgins</b>		4. DATE OF DEATH Month <b>July</b> Day <b>24th.</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1945</b>
9. AGE (In years birth day) yrs. <b>21</b>		IF UNDER 1 YEAR Months <b>24</b> Days <b>24</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>College</b>	
11. BIRTHPLACE (State or foreign country) <b>Pittsburgh, Panna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mark B. Higgins</b>		14. MOTHER'S MAIDEN NAME <b>Jean Genkinger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>188-36-1339</b>	
17. INFORMANT <b>(Father)</b>		Address <b>Mark B. Higgins, Pittsburgh, Pa.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull</b> 8254 DUE TO Crushed chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>One car a uto accident Rt. 219 5mi. N. of Oakland, Md.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>1:15</b> <del>xx</del> <b>7-24-66</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>(Rural) Oakland Garr. Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>7-24-66</b>	
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		Address (Street, city, town, or county) <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/27/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Queen of Heaven</b>		23d. LOCATION (City or Town) (County) (State) <b>Peters Twp. Washington Co Penna.</b>	
24. FUNERAL DIRECTOR <b>John O. Durst</b>		ADDRESS <b>Leighton-Durst Funeral Home</b>	
25a. REC'D BY REGISTRAR DATE <b>JUL 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b> c. LENGTH OF STAY IN 1b <b>18½ hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park</b> d. STREET ADDRESS <b>202 I Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Joseph</b> Last <b>Martin</b>		4. DATE OF DEATH Month <b>July</b> Day <b>7th.</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-16-1882</b>
9. AGE (In years lost birthday) yrs. <b>83</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trackman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Red House, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John L. Martin</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rolf</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-20-5424</b>	
17. INFORMANT <b>Mrs. Ida Sutton</b>		Address <b>Oakland, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH Hours Years 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M.D.</b>		22. DATE SIGNED <b>7-7-66</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/10/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oakland, Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Oakland, Md.</b>	
24. FUNERAL DIRECTOR <b>Charles D. Minnich</b>		ADDRESS <b>Oakland, Maryland</b>	
25a. REC'D BY REGISTRAR <b>JUL 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09963

09955

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b> c. LENGTH OF STAY IN 1b <b>31hrs. 55min</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Mem. Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Gorman, W. Va. // - /</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>BENJAMIN</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>July</b> Day <b>28th</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1892</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Soft Coal</b>	
11. BIRTHPLACE (State or foreign country) <b>Shenendoah Co., Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jeremiah Miller</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Minnick</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>236-14-6858</b>	
17. INFORMANT <b>Mrs. Wayne Liller, Gorman, W. Va.</b>		Address <b>(Dau.)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> M.D.		22. DATE SIGNED <b>7-28-66</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		Address (Street, city, town, or county) <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/31/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Pope Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Gorman, Garr. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>John O. Durst</b>		25a. REC'D BY REGISTRAR <b>John O. Durst</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <b>AUG 1 1966</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

09964

09956

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			c. LENGTH OF STAY IN lb <b>1 day-8 hrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deer Park</b>			11-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles William Niner</b>				4. DATE OF DEATH <b>July 6, 1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1898</b>		9. AGE (In years last birthday) yrs. <b>68</b>	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Timber</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Echard, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Niner</b>				14. MOTHER'S MAIDEN NAME <b>Mary Labor</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-14-55094</b>		17. INFORMANT <b>Mrs. Cora Niner Rt. 2 Deer Park, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Eccentric pulmonary</b> <b>5810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cerebral</b> DUE TO (c) <b>6 mos.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>65</b> , to <b>July</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>July 6</b> , 19 <b>66</b> , and that death occurred at <b>6:40 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>B. L. Grant</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6 July 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. B. L. Grant</b>				22d. ADDRESS <b>Oakland, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/8/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Deer Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Deer Park Maryland</b>		
24. FUNERAL DIRECTOR <b>Gerald N. Minnich</b>				ADDRESS <b>Oakland, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 14 1966</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

09965

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09957

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Garrett</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN lb <b>15 1/2 hrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grantsville</b> <b>11-1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Memorial Hospital</b>			d. STREET ADDRESS <b>11-1</b>		
3. NAME OF DECEASED (Type or print) <b>Cora Ellen Opel</b> First Middle Last			4. DATE OF DEATH <b>July 27th</b> 19 <b>66</b> Month Day Year		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>4/5/1888</b> 78 yrs.		9. AGE (in years last birthday) <b>78</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Keyzers Ridge, Md.</b>	
13. FATHER'S NAME <b>John Opel</b>			14. MOTHER'S MAIDEN NAME <b>Catharine Miller</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>None</b>		17. INFORMANT Address <b>Mrs. Oscar Harman, Accident, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>5702</b> IMMEDIATE CAUSE (a) <b>Mesenteric thrombosis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fractured right hip.</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Apparently fell at home between 22nd. and 25th. of July</b>			
20c. TIME OF INJURY Month, Day, Year <b>Unk. p.m. 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
				20f. (City or town) (County) (State) <b>Grantsville Garr. Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b>		M.D.		22. DATE SIGNED <b>7-27-66</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		Address (Street, city, town, or county) <b>Oakland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/30/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Ch. Cem.</b>	
24. FUNERAL DIRECTOR <b>Ruth E. Newman</b>		ADDRESS <b>Grantsville, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 3 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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09966

## CERTIFICATE OF DEATH

09958

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> <del>WEST VIRGINIA</del> COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN lb <b>20 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GORMANIA, W.Va. - Rural</b> // - /
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>ROUTE # 1 - BOX 16</b>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>SHREVE</b> Last <b>SHREVE</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>26</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>FEB. 20, 1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Saw Mill</b>	9. AGE (In years last birthday) yrs. <b>81</b> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA, Pendleton Co. S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BENJAMIN SHREVE</b>		14. MOTHER'S MAIDEN NAME <b>HANNA CATTERMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-16-2681</b>	
17. INFORMANT (Hosp. Records) Address <b>SELF- WALTER SHREVE -R # 1 - BOX 16</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO (b) <b>coronary atherosclerotic CV disease</b> DUE TO (c) <b>hypertension</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>diabetes mellitus</b>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>7/26/</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7/26/</b> , 19 <b>66</b> , and that death occurred <b>10:45 A.M.</b> , from causes on and on the date stated above.	
22a. SIGNATURE <b>B.I. Grant</b>		22b. DATE SIGNED <b>26 July 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>B.I. GRANT, M.D.</b>		22d. ADDRESS <b>THIRD STREET OAKLAND, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/28/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Gormanian, W. Va.</b>	
24. FUNERAL DIRECTOR <b>John O. Durst, Oakland, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 28 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Pennsylvania</b> b. COUNTY <b>Allegheny</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			c. LENGTH OF STAY IN lb <b>1 Hr. 22 Min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsburgh</b> 75-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS <b>43 Woodside Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Michael Joseph Weisenmiller</b>				4. DATE OF DEATH Month Day Year <b>July 28 1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1966</b>		9. AGE (In years lost birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months Days <b>1 22</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Oakland, Garrett</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>John Conrad Weisenmiller</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Ellen Lutz</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>John Conrad Weisenmiller</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity (5<sup>1</sup>/<sub>2</sub> mos. gestation, Wt. 11b 9oz.)</b> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1hr. 22min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 28, 1966</b> to <b>July 28, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 28, 1966</b> , and that death occurred at <b>6:00 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <i>John H. Feaster, Jr.</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7-28-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. J. H. Feaster, Jr.</b>				22d. ADDRESS <b>Oakland, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/29/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cath.</b>		23d. LOCATION (City or Town) (County) (State) <b>Oakland, Maryland</b>	
24. FUNERAL DIRECTOR <b>John O. Durst</b> <b>Leighton-Durst Funeral Home, Oakland, Md.</b>				25a. REC'D BY REGISTRAR <b>AUG 1 1966</b>		25b. REGISTRAR'S SIGNATURE <i>John O. Durst</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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UNITED STATES OF AMERICA

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